CHRONOLOGICAL RECORD OF WELL-BABY CARE

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General

SIGNIFICANT NEONATAL HX	**DOB**	**WEIGHT**	**HEIGHT**	**PKU**

DATE OF VISIT		
AGE	12 months	15 to 18 months
WEIGHT		
HEIGHT		
HEAD CIRCUMFERENCE		
SUBJECTIVE (HISTORY) 1. FEEDING 2. FORMULA/BREAST SOLIDS VITAMINS/FLOURIDE 3. ELIMINATION 4. GROWTH AND DEVELOPMENT 5. PARENTAL CONCERNS	Milk / Juice _____ Diet: _____ Stools/Day _____ Voids _____ Feeds self with fingers _____ Uses cup _____ Says Da-Da/Ma-Ma and 1 to 3 words _____ Stands alone/support _____ Walks alone/support _____ Pincer grasp _____ Waves bye-bye _____ Bends and recovers _____ Sleep pattern _____ Allergies _____ Current meds _____ Parental concerns _____	Milk / Juice _____ Diet: _____ Stools/Day _____ Voids _____ Walks/runs ___ Climbs ___ Uses spoon ___ Says 5 to 15 words _____ Phrases _____ Points to body parts _____ Builds a 1 to 3 block tower _____ Takes two commands together _____ Allergies _____ Current meds _____ Parental concerns _____ _____ _____
OBJECTIVE **PHYSICAL EXAM**		
NUTRITION		
HEAD/FONTANEL		
EENT		
NECK/CLAVICLES		
LUNGS		
HEART		
ABDOMEN		
GENITALIA/HERNIA		
HIPS/SPINE		
EXTREMITIES		
SKIN		
NEUROLOGICAL		
ASSESSMENT		
PLANS AND COUNSELING SAFETY FEEDING GROWTH AND DEVELOPMENT IMMUNIZATION NEXT VISIT	Dental care discussed. Discussion and handouts given on nutrition, safety, and growth and development. TB tine test order / defer. Hct / Hgb / sickle dex ordered. Tylenol drops / elixir _____ Parents verbalized understanding of instructions. Return to clinic at age _____.	Dental care and toilet training discussed. Discussion and handouts given on nutrition, safety, and growth and development. MMR # _____ DPT/OPV # _____ HIB # _____ order / defer Tylenol drops / elixir _____ Parents verbalized understanding of instructions. Return to clinic at age _____.
	EXAMINED BY	EXAMINED BY

PATIENT'S IDENTIFICATION (Name, last, first, middle, grade, date, hospital or medical facility	REMARKS

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SUBJECTIVE (HISTORY)		
1. FEEDING 2. FORMULA/BREAST SOLIDS VITAMINS/FLOURIDE 3. ELIMINATION 4. GROWTH AND DEVELOPMENT 5. PARENTAL CONCERNS		
OBJECTIVE **PHYSICAL EXAM**		
NUTRITION		
HEAD/FONTANEL		
EENT		
NECK/CLAVICLES		
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HEART		
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HIPS/SPINE		
EXTREMITIES		
SKIN		
NEUROLOGICAL		
ASSESSMENT		
PLANS AND COUNSELING		
SAFETY FEEDING GROWTH AND DEVELOPMENT IMMUNIZATION NEXT VISIT		
	EXAMINED BY	EXAMINED BY

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